

**Mental Illness and Mass Incarceration:
Reframing the Analysis of the U.S. Criminal Justice System**

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Abstract

There has been a recent, increasingly bi-partisan focus on solving the issue of mass incarceration in the U.S. However, many of the supporting arguments and policy proposals have been made from an economic, cost-benefit analysis framework. These perspectives overlook the pervasive problem of mass incarceration of the mentally ill. I argue that the United States has specific moral and social obligations to specifically decrease the mass incarceration of the mentally ill because failure to do so threatens the wellbeing and basic liberties of individuals as well as the fundamental justice of our criminal justice system. I support this argument by using John Rawls's theory of justice as fairness, as articulated by Daniels et. al (2002) and Loury (2008). I also believe that Young (2004) would support the concept of a societal responsibility to curb mass incarceration of the mentally ill for moral reasons. Three broad policy proposals are suggested to reform our current system: improving the availability of mental health services to the currently incarcerated, decreasing the chance that seriously mentally ill individuals are sent to jail, and increasing preventative mental health care in low-income African American communities.

Suzanne's* story is individual, but not exactly one in a million. She was transferred from her local jail to Western State Psychiatric Hospital after being arrested in her hometown for misdemeanor trespassing and shoplifting. Police found Suzanne in a nearly catatonic, or unresponsive, state when she was arrested, but Suzanne experienced a full-blown psychotic episode once she was brought to the jail. She was hypersexual, would not shower because she was having delusions about people spying on her through the windows and shower drains, and used her own feces to write on the walls. Once she was admitted to Western State, Suzanne was diagnosed with schizophrenia and placed on antipsychotic medication. She could not remember anything about her arrest or what her charges were. Just a few years before her arrest, Suzanne was an athlete in high school and received a full scholarship to attend college and continue playing basketball. Coming from a low-income African American neighborhood, Suzanne would have been the first in her family to attend college. Not long after she began college, however, Suzanne experienced an extremely traumatic, life-altering event – she was gang raped by a group of boys who lived in her neighborhood. Soon after the attack, Suzanne dropped out of school without receiving any substantive counseling and without filing charges against her attackers. Suzanne's aunt, her mother's identical twin sister, committed suicide a few years ago. According to staff members at the hospital, Suzanne's mother was dismissive of the topic when it came up in an initial interview and Suzanne's treatment team at Western State speculates that the family did not fully address the suicide as a matter of mental illness. Psychoeducation, or education about a mental illness offered to individuals and their families for coping and empowerment, is especially difficult to teach in a family or community where mental illness has historically been overlooked or brushed aside. All of these factors amounted to a perfect storm for the emergence of a mental illness in Suzanne and also gave her a somewhat bleak prognosis for her future after discharge from Western State.

Unfortunately, despite just how horrific and heartbreaking it is, Suzanne's story is not unique in nature. There are far too many people like Suzanne who currently, and unjustly, populate our jails,

* Pseudonym will be used to protect the identity

prisons, and state psychiatric hospitals. Though too often unseen, mass incarceration and its intersection with mental health, poverty, and race will prove to be the defining social justice issue of our generation. Visibly or not, mass incarceration has already directly and indirectly affected the lives of millions of Americans and our response to this issue will reflect our values as a nation. Fortunately, many Americans have begun to recognize the issue of mass incarceration and many political leaders have proposed policies to curb the practice of it. Regardless of political allegiance or the type of arguments made about why we should end mass incarceration, many Americans would agree that the mass incarceration of the mentally ill is morally intolerable. In keeping with this increasingly popular movement to decrease mass incarceration more generally, I argue that the United States has moral and social obligations specifically to decrease the mass incarceration of the mentally ill. Failure to do so threatens the basic liberties and health/wellbeing of individuals as well as the fundamental justice of our criminal justice system. In order to curb the use of our carceral institutions as psychiatric wards and reliance on psychiatric hospitals, I argue that we must first improve the current availability of mental health services to those currently incarcerated. Second, we must decrease the chance that seriously mentally ill individuals are sent to jail in the first place by implementing more alternative and diversion tactics. Third, our responsibility extends to increase preventative mental health care in low-income African American communities.

The Problem: Disparities Within the Criminal Justice System

Over the past few decades, the United States has seen a precipitous and unprecedented rise in the number of Americans who are incarcerated or under some form of correctional supervision, such as probation or parole. The U.S. currently holds a total of approximately 2.3 million people in our juvenile correctional facilities, state prisons, federal prisons, and local jails, which amounts to about 25% of the world's incarcerated population (Wagner & Rabuy, 2015). According to the Bureau of Justice Statistics, 1 in 110 adult residents of the U.S. were incarcerated in the year 2013 and 1 in 35

were under some form of correctional supervision (Glaze & Kaeble, 2014). This massive number of Americans under correctional control has swelled by 700 percent since the 1970s (Cloud, 2014).

Racial disparities. The racial disparities prevalent in this spike of incarceration have significantly and disproportionately affected African American communities. According to Drake (2011), White men were incarcerated at a rate of 678 per 100,000, while African American men were incarcerated at a rate of 4,347 per 100,000 in the year 2010. In other words, African American men were six times more likely to be incarcerated than White men in 2010. Even though African Americans only make up 13 percent of the United States population, the Bureau of Justice Statistics found that African American males made up more than 37 percent of federal and state prison population in 2014, compared to 32 percent of White males (Carson, 2015). Over the past 31 years, rates of arrest for African Americans have fallen for both violent and property crimes, but have dramatically increased for nonviolent drug crimes due to the harsh punishments imposed during the War on Drugs and 'tough on crime' era. African Americans are 3.6 times more likely to be arrested for selling drugs and 2.5 more likely to be arrested for possessing drugs compared to Whites, despite the fact that White Americans are actually more likely than African Americans to sell drugs and equally as likely to use them. The rates of arrest for drug possession and drug paraphernalia expose a vast racial inequality in arrests, convictions, and sentencing in our criminal justice system (Rothwell, 2014).

Socioeconomic disparities. Although race and socioeconomic status are very much correlated and it is virtually impossible to disentangle the two, those living in poverty have also been disproportionately affected by mass incarceration. Incarcerated individuals of all genders, races, and ethnicities earn much less money prior to incarceration than their similarly aged cohorts who are not incarcerated (Rabuy & Kopf, 2015). According to Rabuy and Kopf (2015), incarcerated individuals earned 41 percent less than non-incarcerated individuals of similar ages. The Bureau of Justice Statistics 1991 Survey of State Prison Inmates found that only 34 percent of all state prison inmates

had completed high school (Beck et al., 1993). Our jails and prisons are teeming with Americans who receive little education, have virtually no access to economic opportunity (especially after incarceration), and are concentrated at the lowest ends of the distribution for national income (Rabuy & Kopf, 2015). With the burden of having a criminal record, ex-offenders are less likely to find gainful employment and are more likely to recidivate and return to jail or prison, fueling the vicious cycle of poverty and incarceration that we continue to see today.

This does not occur simply because individuals living in poverty necessarily commit more crimes than non-poor individuals. In fact, the 1967 President's Crime Commission found that 91 percent of all Americans had violated laws that could potentially have subjected them to incarceration at one point in their lives (Katzenbach, 1967). However, there is bias in arrest rates, convictions, and sentencing that does tend to disadvantage the least advantaged among us. Due to the high rate and presence of policing in areas of concentrated poverty, African Americans and those living in poverty are more likely to be stopped and frisked as well as arrested for street crimes, which are criminal offenses that occur in a public space, such as an open air illegal drug trade, loitering, or vandalism (NYCLU, 2013; Barkan, 2012). Americans with more wealth have an increased ability to afford private space and homes in safer communities, thus are less likely to be highly policed or caught using or selling drugs outside.

Once an individual living in poverty is thrust into the criminal justice system after being stopped, arrested, convicted, and/or sentenced, the odds are further stacked against them. Those who cannot afford bail must stay behind bars. Those without an attorney must wait for a public defender, and, if they receive one, they will likely meet with their overworked counsel for only a very brief time before going to court. In the U.S., failure to pay fines and fees associated with the criminal justice system can also cost a person time in jail. For example, a homeless Iraq War veteran in Michigan was sentenced to 22 days in jail, not as a result of his arrest for getting drunk with his friends and climbing into an abandoned building, but for the simple fact that he only had \$25 in his

pocket the day he went to court and was unable to pay his fines and court fees. How can it be that our criminal justice system is allowed to send people jail and prison simply because they are poor?

According to a National Public Radio investigation, at least 43 states in the U.S. can make defendants pay fees for a public defender, 41 states can charge inmates for room and board at jails and prisons, and 44 states are able to charge offenders for the cost of probation and parole supervision (Shapiro, 2014). Although debtor's prisons have been illegal in the United States for many years, our criminal justice system has allowed some of our prisons and jails to function in the same fashion as debtor's prisons. Freedom certainly is not free, especially for those without any resources.

Mental health disparities. Individuals with serious mental illnesses and substance use disorders are also more likely to be incarcerated. According to the Vera Institute of Justice, 31 percent of women and 14.5 percent of men in our nation's jails and prisons have been diagnosed with a serious mental illness, such as bipolar disorder, schizophrenia, or major depression. These numbers are especially alarming when we compare them to the general population where only 4.9 percent of women and 3.2 percent of men are diagnosed with these serious mental illnesses (Cloud, 2014).

Individuals with serious mental illnesses will often self-medicate and become substance dependent in the process, further deepening the psychological and physical toll of the mental illness. Fully 72 percent of incarcerated individuals who have a serious mental illness also have a comorbid substance use disorder, or what is more commonly known as a drug addiction (Cloud, 2014). Compared to jail and prison inmates without mental health problems, inmates with mental health problems are more likely to have done drugs in the month prior to arrest, been homeless in the year before arrest, have a history of sexual or physical abuse, have parents who abused drugs or alcohol, and possess a history of trauma stemming from abuse (James & Glaze, 2006). Compared to state and federal prisons, local jails have the highest prevalence of mental health problems. Nearly two-thirds of inmates at local jails meet criteria for a mental illness currently or in the previous year (NIMH).

The Roots of the Problem: Mental Health Care, Race, and Mass Incarceration

How is it possible that our nation's jails and prisons have become the new psychiatric wards for these disinherited populations? One major factor that has contributed to where we are today was the process of deinstitutionalization that began in the late 1950s. The tide of civil rights activism reached state mental asylums, which held a number of civilly committed citizens, some of whom were being held indefinitely. Asylums functioned much like prisons for the mentally ill, but patients were often brought to asylums without any trial or representation. Activists successfully argued that such conditions of confinement were not conducive to treatment and demonstrated that asylums were often punitive and inhumane to their patients, many of whom were not even mentally ill but were rather intellectually disabled. People demanded an alternative method of treatment in the community for mentally ill individuals so that they could remain close to home and retain some autonomy over their lives. This concept, combined with the discovery of the first effective antipsychotic drug in 1955 and the advent of Medicare/Medicaid in 1965, effectively made the case that treatment should occur in the least restrictive setting possible. Thus, asylums would no longer be relied upon as the primary treatment route for the mentally ill. States closed their asylums in large numbers and patients were released to their communities, often without receiving the necessary medication and treatment plans to succeed in those communities. Unfortunately, lawmakers in the United States never fully followed through with their plans to create robust community-based behavioral health treatment centers for the mentally ill due to financial reasons (Torrey, PBS).

Though the spirit of deinstitutionalization was well intended and just, its actual results and effects have been less than desirable in terms of the fate of mentally ill individuals and incarceration rates. Because so many of these patient-focused community behavioral health centers were never created, the mentally ill were often left with no structural support and nowhere to seek appropriate or affordable treatment. After state asylum closures and the cutting of a number of social safety net programs in the 1980s, many mentally ill individuals ended up in a state of homelessness. Many also found their way to jails and prisons during this time period in which the U.S. concurrently declared

its War on Drugs and then began the tough-on-crime era of policing and sentencing - two trends that are perhaps most responsible for the unparalleled rise in rates of American incarceration (Cloud, 2014). For example, the War on Drugs is at least partly responsible for the disparities in rates of incarceration for White and African American citizens. As previously mentioned, despite similar rates of drug use among African Americans and White Americans, African Americans are thirteen times more likely than White Americans to go jail for drug convictions and they comprise 62 percent of all people imprisoned for a drug conviction (Cloud, 2014).

All of these trends, statistics, and narratives lead to one disturbing theme: a great lack of mental health care in the U.S. This is especially true among low income and minority groups. For those with the resources, private treatment is a readily available option; however, private mental health care is too costly for most Americans. It is also unfortunately true that mental illness is still highly stigmatized and widely spoken of as a personal, moral shortcoming or failure as opposed to a health concern, particularly in the African American community. In fact, 63 percent of African Americans believe that depression is a personal weakness, which is higher than the 54 percent national average, and only 31 percent of African Americans believe that depression is an actual “health problem” (MHA). Although African American adults are 20 percent more likely than White adults to report serious psychological distress, only 8.7 percent actually receive treatment for mental health concerns, compared to 16 percent of White adults.

Part of this disparity could be because many African Americans do not trust physicians or healthcare practitioners in general when compared to White Americans. This lack of trust is certainly not unfounded when we take history into consideration. Enslaved individuals were subject to dangerous and deadly medical experiments throughout the centuries of slavery in the U.S. Post-slavery, medical experimentation continued to target African Americans both as prisoners and as soldiers. Many African Americans believe that sickle cell screening, the AIDs movement, along with family planning and involuntary sterilization, were attempts by the government to control the African

American population and dictate the race's mating behaviors (Randall, 1996). Another hugely influential event in the development of this distrust of medical professionals was the Tuskegee syphilis experiment that lasted from 1932-1972. During this time period, the Public Health Service studied the effects of untreated syphilis in poor, southern African American sharecroppers by lying to the farmers and telling them they were receiving free healthcare from the U.S. government. The men did not know they had the disease and the experimentation continued although penicillin, the cure for syphilis, was used regularly to treat the disease after 1947 (CDC). These and other various forms of racism and systemic oppression throughout our nation's history served to build up a lasting hesitation within the African American community to trust White people, particularly those with authority such as medical professionals. Even after the Belmont Report, which established ethical guidelines for research with human subjects following the Tuskegee experiments, and the gains made by the Civil Rights Movement, there still exist disparities in medical treatment between White and African American populations. For example, doctors are more likely to prescribe adequate pain medication in the form of an opioid prescription to non-Hispanic White patients in emergency treatment settings than they are to ethnic minorities, such as African American and Hispanic patients, due to stereotypical beliefs and implicit biases (Pletcher et al., 2008).

Cultural norms, expectations, and stigmas about mental illness and mental health care grew around these collective, negative encounters with the healthcare system in the U.S. According to African American psychiatrist Dr. William Lawson, African Americans tend to have a great deal of negative feelings about mental health care, while many others are simply unaware that mental health services even exist. African Americans are often not aware of the symptoms of many mental illnesses or they believe that asking for help with a mental illness is a sign of weakness or an internal character flaw. In an interview with National Public Radio, Dr. Lawson also broached the topic of trust, again pointing out that African Americans tend to want to seek treatment only from trustworthy institutions with which they are familiar (Donvan, 2012). When Dr. Lawson was in medical school, his

professors falsely told him that African Americans do not suffer from depression or bipolar disorder. It is alarming to think that such falsehoods may still be circulating among African Americans and are likely still a part of belief patterns. Resulting from and reinforced by these combined factors, minorities in the U.S. have less access to mental health services than Whites, are less likely to seek or receive needed care, and are less likely to receive the best available care when they are treated (McGuire & Miranda, 2008). African Americans' utilization of mental health services is characterized by very high rates of emergency care, meaning they are more likely to only receive treatment when it is absolutely necessary, or when the situation is bad enough to go to the emergency room (Satcher, 2001). Compared to White Americans, African Americans are also more likely to be treated in a psychiatric hospital (Tweedy, 2015). African Americans have lower rates of outpatient treatment and are more likely than White Americans to terminate treatment early, meaning they are less likely to remain in necessary extended care. This could be due, in part, to the fact that African Americans often end up in treatment because they are legally obligated or coerced to be there (Satcher, 2001). All of these uses of mental health treatment amount to being too little, too late.

Insurance coverage has also historically reinforced the stigmatization of mental illness by making a grave distinction between illnesses of the brain and illnesses of the body, placing a greater emphasis on physical ailments than on psychological ailments (Satcher, Kennedy, & Reed, 2016). The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 sought to ensure equity in insurance coverage of mental health and substance use disorder treatment. The Affordable Care Act (ACA) furthered the reach of the Parity Law by requiring insurance companies to cover mental health treatment, including treatment for substance use disorders. These legislative efforts, however, mean little when they are not strictly enforced and if people remain unaware of their rights to access equitable mental health care covered by insurance. A top priority for lawmakers and those in the healthcare field must be to enforce the Parity Law and the full extent of the ACA, as well as to educate Americans about their right to access mental health coverage (Satcher, Kennedy, & Reed,

2016). Despite the fact that adults of color in the U.S. are more than twice as likely as White Americans to be uninsured, and thus are less likely than White Americans to regularly see a primary care physician, the Affordable Care Act is extending mental health coverage to more and more Americans every day (Cloud, 2014). The ACA has the potential to aid in a more widespread network of mental health care delivery. Medicaid expansion has the potential to support more diversion programs and community-based care models, as well as to facilitate partnerships between justice and health systems to cover more substance abuse and mental health treatment (Cloud & Davis, 2013).

The fact that the MHPAEA has been such a recent development can be seen as evidence of a longstanding denial to perceive mental health as a genuine basic concern, and this has been especially true in jails and prisons. Jails and prisons would look and function in a much different manner if they were truly taking into account mental health and being used for their stated intent, which is supposed to be, first and foremost, rehabilitation of offenders. Since African Americans and individuals living in poverty are both disproportionately likely to be incarcerated and are among the least able or likely to receive necessary mental health care, it follows that these groups are among the most likely to be arrested and incarcerated due to an untreated mental illness.

Though state psychiatric hospitals may still be necessary for the proper functioning of our criminal justice and mental health care systems, we should not rely on them as much as we currently do, or rely on them for long-term care of mentally ill or intellectually disabled individuals. Ideally, these hospitals should be used mainly as a transitional placement as opposed to a long-term care alternative for the mentally ill. Criminal offenders with mental health problems should be treated primarily in an improved jail or prison setting. Only if treatment is not possible or safety is an imminent risk should inmates be sent to state psychiatric hospitals for stabilization. Mentally ill individuals with long-term care needs should be transitioned back into the community as soon as possible, so that they may live and be treated in the least restrictive environment possible. This could

only occur if jails and prisons were to vastly improve their ability to provide mental health care and if communities invest heavily in community-based alternatives and behavioral health treatment centers.

Our nation's various institutions of incarceration should be reserved for the worst offenders in society, not, for example, those who have committed crimes due to an untreated mental illness or those who steal to sustain substance dependence. Until we are able to put in place a stronger, more comprehensive public mental health system, we can take a number of steps to properly equip and train the criminal justice system and its agents to better deal with mentally ill individuals. There are ways that we can address and prevent these troubling trends of incarceration and mental health care neglect from continuing to occur. Like most answers to important questions, the answers to these problems are not and cannot be simple. We cannot simply decarcerate based on mental illness or continue to funnel mentally ill inmates through psychiatric hospitals, because these hospitals are already vastly underfunded and overburdened.

Responses to the Problem: I. Treating the Currently Incarcerated

With some of these limitations in mind, what *should* we do? In order to address the injustices present in the fact that our carceral system is being used as a psychiatric ward, we must take a seemingly obvious first step: improve current conditions of incarceration and provide increased access to mental health treatment for the currently incarcerated.

In many instances, health problems, both physical and psychological, are not addressed in jails and prisons despite the obviously high need for treatment and care among incarcerated populations. This is true despite the U.S. Supreme Court's affirmation that carceral institutions have a responsibility to provide treatment for schizophrenia, bipolar disorder, and other mental illnesses just as they should for physical ailments like diabetes and hypertension. However, according to the National Alliance on Mental Illness, 83 percent of mentally ill individuals in jail do not have access to crucial treatment (NAMI). Fewer than half of jail and prison inmates who have a mental health problem have ever received treatment for that problem. These statistics should be very alarming

considering the particularly high number of individuals with mental illnesses in our nation's jails and prisons. Inmates at local jails are the least likely to receive mental health treatment - in the form of medication (14.8%), therapy (7.3%), hospitalization (2.2%), or any treatment at all (17.5%) - compared to inmates in state prisons (26.8% of whom receive medication as treatment, 22.6% therapy, 5.4% hospitalization, and 33.8% receive treatment of any kind) (NIMH). This large disparity is very concerning, given that local jails have the highest prevalence of mental illness among any institution of incarceration.

For incarcerated individuals with a substance use disorder, less than 15 percent receive appropriate treatment (Cloud, 2014). Correctional facilities rarely offer methadone or buprenorphine treatments, although these pharmacological solutions are often the most effective treatments for some opioid dependent individuals. The lack of effective treatment options subjects opioid dependent individuals to a high risk of painful physical withdrawal while incarcerated and also increases the risk of drug overdose when they return back to their communities after release (Cloud, 2014). In many jails and prisons, the only treatment option available to individuals with a substance use disorder is Alcoholics Anonymous (A.A.) or Narcotics Anonymous (N.A.), which is a discussion-based mutual aid fellowship that follows a 12-step program. The program is based in spirituality, not one specific religion. A.A. and N.A. meetings are not required to be held at most local jails, so they are often only held when individuals volunteer to hold them. On a national and international scale, the program is often successful and effective at helping many individuals maintain sobriety. Other individuals, like my own brother who is opioid dependent and atheist, have found it difficult to fully commit to the A.A. and N.A. programs due to its religious undertones. Outside of these and other various self-help or peer counseling groups, there are few or no available treatment programs led by a trained professional for substance abusers, especially in local jails.

Increased availability of treatment options in jails & prisons: pharmacological treatments.

Because of this, local jails and prisons should make available more evidence-based treatment options,

including methadone and other psychiatric medications, for incarcerated individuals with mental illnesses and substance abuse problems. While prisons are permitted to administer certain medications, and jails to a lesser extent, there should be a wider array of medication available to inmates and a more effective system in place for accessing these much-needed medications. For those in local jails, the availability of medication is typically very limited. For example, while my brother was in jail, he was forced to stop taking almost all of the medications he was using to manage his anxiety and treat his chronic pain. When he complained of extreme back pain, he was examined by the doctor at the jail, given ibuprofen, and advised to buy another mattress pad. Though it is admittedly very difficult to take an opioid abuser at his word, my parents took him to the doctor when he was released from jail only to have his stories of pain fully corroborated; he had osteomyelitis along his spine, a very rare bone infection he likely contracted through intravenous drug use. The whole time he was in jail, however, he was in excruciating pain and he did not receive the treatment he needed. Jails frequently refuse to accept medications brought to the jail by an inmate's family due to legal liability issues, and many of the medications are too expensive for the jail to afford on their own. This issue could be partly resolved if laws were written so that correctional officials would be protected under a "good faith" provision if they allowed family members to bring an inmate's medications to the jail, with some necessary restrictions (Torrey, Zdanowicz, Kennard, Lamb, Eslinger, Biasotti, & Fuller, 2014).

When it comes to treating substance abuse and drug dependency, finding the "right" treatment is very difficult. Drug addiction is also a mental illness, not a chosen condition like many people assume. As previously mentioned, A.A. or N.A. works for some, but this is not the case for all addicts. After having tried just about every other form of inpatient and outpatient treatment, my brother has been using methadone treatment for his opioid dependency as a virtual last resort. Methadone reduces symptoms of withdrawal for opioid dependent individuals and serves as a replacement opioid, but without causing the effect of getting high. The methadone clinic is very strict

when it comes to giving doses of the drug and it is a very regimented, scheduled treatment. Being sent to jail or prison and withdrawing from methadone, cold turkey, severely disrupts this pattern of treatment and continuity of care for addicts and causes prolonged, uncomfortable withdrawal symptoms. In addition, it is very costly to continually start and stop the treatment, especially for those without insurance or the means to obtain treatment. Although some of these necessary medications do have high potential for misuse or abuse, there is also the chance that people will truly suffer undue harm without taking them.

It is also the case that those who need antipsychotic drugs the most, like individuals with schizophrenia, are also often the least likely to stick to a routine habit of taking them. Though inmates are obviously free to tell other inmates what they want about the medications they take and the conditions they have, the fact that inmates must congregate in the “pill line” to receive medication further stigmatizes mental illness and disincentivizes taking one’s medication. Jails and prisons could have nurses more privately and carefully administer the drugs then check that inmates have actually swallowed them.

Increased availability of treatment options in jails & prisons: behavioral therapy treatments.

Behavioral therapy is another area through which improvements can be made in the treatment of incarcerated populations. Treatment programs based on social learning, cognitive-behavioral models, skills training, and family systems approaches are effective and can help reduce recidivism, so these forms of treatment should be more widely available in carceral institutions. Although 65 percent of prisons offer substance abuse counseling, that means fully 35 percent of prisons do not offer any substance abuse counseling. Of those prisons that do offer counseling, 98 percent offer group counseling and 84 percent offer individual counseling (SAMHSA). Inmates may be even more reluctant to open up in a group setting when we take into account the fact that they are living in such a hostile and restrictive environment, both physically and psychologically. Individual forms of therapy should be offered to inmates at the same rate that group therapy is offered, and therapy

should be offered to individuals beyond those who are the most severely mentally ill. Additionally, the outcomes of both individual and group therapy should be checked by empirical data to make sure they are effectively helping to treat people and fulfill their intended purpose; if not, the form and intensity of the therapy should be altered to achieve more successful outcomes.

Ending the trauma of incarceration. However, in order to successfully implement any of these improvements in approaches to mental health care in jails and prisons, institutes of incarceration must first stop applying harmful strategies to deal with mentally ill inmates. Compared to inmates without a mental illness, those with a mental illness are more likely to be violently victimized by other inmates and correctional staff. They are also more likely to be housed in a segregation unit or placed in solitary confinement and are confined for longer periods of time (Cloud & Davis, 2013). The result of each of these situations is trauma and further deterioration of mental health and sanity in already mentally unstable and vulnerable individuals. Jails and prisons should have improved access to health care records for inmates and more careful intake screenings for mental illness should be established for when an inmate arrives at the jail or prison (Torrey et al., 2014). In this day and age of technological advancement, there should be no excuse for not having consistent and accessible health care records for individuals. Correctional officers and staff would also benefit from being trained in crisis intervention team training (CIT) or a more general mental health training program to effectively deal with mentally ill inmates. This could help curb the use of violence and segregation as disciplines for infractions, since mentally ill inmates have much higher rates of infractions (Lewis, 2015). A study in Indiana found that just ten hours of mental health training for correctional officers led to a significant decline in the use of force by correctional officers. The training session also led to less battery of correctional officers by inmates. This highlights the mutually beneficial role of mental health training, as it can lead to safer working conditions for correctional officers, as well as safer and more humane living conditions for inmates (Parker, 2009). To further improve the mental health and meet the needs of mentally ill incarcerated

individuals, the trauma of incarceration itself must be addressed. Inmate and guard violence, overcrowding, frequent lockdowns, sexual victimization, poor nutritional standards for food, lack of natural lighting, and isolation can all combine to easily undo any positive effects of improved treatment standards. There are a number of ways that our jails and prisons can be improved to reflect a more treatment-oriented environment, but a further discussion of those many improvements goes beyond the scope of this paper.

Continuity of care and ending the service gap. Continuity of care is another major issue facing incarcerated mentally ill individuals. While improvements in quality of care are important for currently incarcerated individuals, the organization of that care is arguably just as important. Currently, there is minimal oversight for correctional health services and often a great lack of communication and coordination between an inmate's health care providers inside and outside the jail or prison walls (Cloud, 2014). There should be a more effective system in place to connect care providers before, during, and after an individual's period of incarceration to most effectively coordinate treatment and continue care. Another way to improve this continuity of care problem would be to end the service gap for individuals being released from jail and prison. Medicaid dollars cannot be spent on healthcare services for incarcerated individuals, a rule known as "the inmate exclusion." Unfortunately, the Affordable Care Act did not change this longstanding rule. Though the federal government encourages local and state systems to suspend then reinstate benefits, all but 12 states in the U.S. terminate Medicaid for individuals following a period of incarceration of 30 days or more and do not reinstate it upon release (Cloud, 2014). Because incarcerated individuals are the ones who often have the most need in terms of health care, then we should end this exclusion and mandate state and local governments to not suspend Medicaid benefits for inmates. For those with a serious mental illness, having Medicaid when they are released increases the chances that they will utilize behavioral health services in the community and reduces the rate of recidivism, as untreated mental illness is associated with higher rates of recidivism (Cloud, 2014; Lewis, 2015). Since the

immediate period of time after release is characterized by an increased risk of death and disability, having Medicaid is often necessary to provide reentry health protections.

If not for any other reason or moral obligation, we must provide increased care for mentally ill inmates because it is our legal obligation. Individuals held in the correctional system are the only group in the United States with a constitutional right to health care (Cloud, 2014). Narrowly construed, this means a guaranteed right to physical health care, but broadly construed and in light of the Mental Health Parity and Addiction Equity Act of 2008, that also means a guaranteed right to mental health care. To ensure that this health care is being properly and adequately provided to incarcerated individuals, there must be more oversight and uniform quality standards for care. Only about 17 percent of correctional facilities are currently accredited by organizations like the National Commission on Correctional Health Care, which sets standards for healthcare services (Cloud, 2014).

Responses to the Problem: II. Diversion from Jail and Prison

Increasing the availability and quality of mental health treatment for currently incarcerated mentally ill individuals is a major first step, but another necessary step towards ending the unjust incarceration of mentally ill individuals is to divert them from entering the criminal justice system wherever and whenever possible.

The proper functioning of our criminal justice system depends upon individuals voluntarily committing crimes. Unfortunately, due to the variable nature of mental illnesses, it is often extremely difficult to tell whether or not an individual was fully aware of the law or in control of their actions when they committed a crime. Individuals with a mental illness who are experiencing a psychotic episode genuinely do not have control of their behaviors at that time, even if the nature of their illness allows them to believe that they are in control. Serious mental illnesses, like schizophrenia and bipolar disorder, are often marked by such delusions and lack of insight. More often than not, the first instinct we have when we see someone in a psychotic episode is to call the police, such as was the case with Suzanne. However, this decision could result in two extremely different outcomes,

depending on the training of the attending officer and the circumstances under which an emergency call was made. If the officer is well trained and prepared to recognize and deal with a behavioral/mental health crisis, then the outcome could be peaceful and beneficial for all parties. The mentally ill individual would ideally be taken to the hospital for acute care and the situation would not have to be dangerous. However, if the attending officer is untrained in matters of mental health and does not know how to recognize a mental health crisis when they see it, there is a possibility that the situation would not be handled in a safe or optimal manner. In the case of the second scenario, sometimes the outcomes can be violent, even fatal, if the officer feels threatened enough to utilize his or her taser or gun. It is a terrifying reality that an individual with an untreated mental illness is 16 times more likely to be killed by police than other citizens who are approached by police officers (Lopez, 2016).

Crisis intervention team (CIT) training. Unfortunately, most law enforcement officers have tended to follow the latter route and end up bringing mentally ill individuals to jail, rather than to the hospital, leading to our current problem of over-incarcerating the mentally ill. Universal training of all police officers in de-escalation and crisis intervention team (CIT) techniques can help break this pattern and divert mentally ill individuals from the criminal justice system. The CIT model reduces stigma surrounding mental illness and uses 40-hour comprehensive training of patrol officers and dispatchers to emphasize crisis resolution skills, mental health-related topics, de-escalation training, and community-based services. The format and curriculum of the training consists of lectures on topics ranging from family perspectives to personality disorders, visits to mental health facilities, intensive interactions with individuals who have a mental illness, and scenario-based skill training (Dupont, Cochran, & Pillsbury, 2007). By being able to recognize and effectively deal with a situation that is a behavioral crisis, officers have the power to change the outcome of a potentially dangerous and life-altering event. To help facilitate the success of CIT training, police departments should implement more community policing strategies so that officers are able to spend time in and

get acquainted with the community in which they are serving. In addition to this highly intensive and comprehensive training, special attention should be paid to educating police officers about the role of implicit bias and historical stigmatization of marginalized groups based on race, SES, religion, and mental illness.

Alternatives to incarceration: drug and mental health courts. In the case that criminal charges are pursued, mentally ill or substance dependent individuals who commit crimes should be considered for any number of alternatives to incarceration (ATIs), including probation, home confinement, halfway houses, and community service. The most ideal ATIs, however, are mental health and drug courts. Drug and mental health courts were founded on the idea of interdisciplinary therapeutic jurisprudence, or using the law to encourage treatment and recovery by bringing together justice agencies, health, and social service providers to avoid the use of incarceration and promote the use of community treatment services (Cloud, 2014). These courts give judges more options for sentencing, save taxpayers money, reduce crime, and allow offenders to remain a part of their families and communities (FAMM).

The sentences handed down by drug and mental health courts typically consist of various combinations of court-supervised inpatient and outpatient treatment programs and sometimes community service, depending on the individual's level of functioning. However, these sentence recommendations must be strict and should also take into consideration more heavily the type of crime that was committed and what needs it might reflect in an offender. Drug and mental health courts are unique and have the potential to be very effective in an individual's life because they can work with individual variation. For example, if a drug dependent individual is arrested for shoplifting, which he or she committed in order to sustain an addiction, then substance abuse treatment in combination with job training and job search help might be most mutually beneficial. Unfortunately, without a rigorous recovery program in place and an appropriate support system,

many individuals will relapse or not follow through with court orders. Often, a first-time drug offender in drug court may be ordered to attend an outpatient program just once a week and go to a certain number of A.A. or N.A. meetings a week. Thus, sentencing in drug and mental health courts must be strict and rigorous enough to make substantial change in an individual's life.

Responses to the Problem – III. Preventative Mental Health Care in Communities

Even if currently incarcerated individuals receive improved mental health treatment and we also work to prevent the mentally ill from being sent to jails and prisons in the first place, we must still consider the communities to which these mentally ill inmates and individuals will eventually return. We should focus on communities that are most at risk by implementing preventative mental health care measures in those communities. Communities at risk for having high rates of mental health problems are those that are characterized by high rates of unemployment, crime, substance abuse, and homelessness (Satcher, 2001). These characteristics are much more likely to be found in communities that contain a majority of African Americans (MHA). Residential segregation is still present in the U.S. today and there is a strong tendency for poor African Americans to live in racially segregated neighborhoods alongside other African Americans who also live in poverty, creating areas of highly concentrated poverty (Boustan, 2011). Individuals in these communities are more likely to have been a victim of or witness to violence, thus there is a high potential for these individuals to have a history of trauma. Additionally, low socioeconomic status correlates with poor health conditions, lower levels of educational attainment, and cyclical, intergenerational poverty (American Psychological Association). Living in a society full of structural racism, prejudices, and implicit biases could itself be considered a trauma - a mentally and physically taxing one that African Americans must confront on a daily basis.

Ideally, preventative healthcare measures in such high-risk communities would be able to catch and treat mental health problems when they begin to form in an individual's life so they do not later use mental health treatment as damage control, after the damage has already been done.

Furthermore, the goal of these initiatives would be to prevent individuals with a mental health problem from ever becoming involved with the criminal justice system. In fact, accessible treatment that keeps mentally ill individuals out of the criminal justice system is actually the most cost-effective strategy, according to the Vera Institute of Justice (2013). In order to accomplish this and other rectifying measures, we must create and utilize mass screenings for mental illnesses, use collaborative care models, and work to end the stigmatization of mental illness through a high profile, educational media campaign.

Preventative screenings for mental illness. Screenings for mental health problems can be woven into primary care settings via routine check-up appointments. This concept of getting a concurrent “check up from the neck up,” along with a physical has gained traction in recent years. For example, depression has been widely discussed in this capacity (Khan, 2016). This year, the U.S. Preventative Services Task Force (USPSTF) updated its guidelines on depression screening for the first time since 2009. The USPSTF now recommends “screening for depression in adult populations, including older adults and pregnant and postpartum women.” This depression screening guideline was given a “B” letter grade by the USPSTF, meaning that the task force recommends the service and “there is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial,” (USPSTF). Depression screenings are as benign as having the patient fill out a questionnaire but, in the absence of this form of mass screening, general practitioners miss up to half of major depression cases. This letter grade puts depression screening guidelines in the same category as yearly mammograms and lung cancer screenings for at-risk patients. This step seems very reasonable when we consider the fact that over 20 million Americans over the age of twelve suffered from moderate to severe symptoms of depression between 2009-2012 (Khan, 2016). The USPSTF report recognizes the great individual and societal costs of depression and notes that the benefits of mass screening for depression outweigh the risks of screening. The task

force does caution, however, that screenings should be set up to ensure the most accurate diagnosis, effective treatment planning, and proper follow-up for patients (USPSTF). If mass screening is effectively undertaken for depression, then the door could be opened for screenings for other mental illnesses, such as schizophrenia and bipolar disorder. Mass-screenings for these other mental illnesses could potentially be done on a patient-by-patient basis when the physician is able to determine family history and take patient history, as well as current circumstances, into account.

Collaborative care models. What happens after a physician recognizes a patient's mental health is in jeopardy, via a mass screening assessment or by other means? A simple referral to a mental health professional would not be enough to ensure that the patient pursues and receives the necessary care. In addition to the use of preventative screenings for mental illness, collaborative care models must be explored in order to further and most effectively reduce the negative effects of mental illness in an individual's life. The collaborative care model would bring together the patient's primary care physician, a behavioral health professional, and a case manager/social worker. Currently, communication across these different realms of treatment is very rare and this lack of communication often serves as a barrier for an individual's recovery. This collaborative care model is used at Western State Hospital; every patient has a treatment team, which consists of the psychiatrist, psychologist, and social worker. The patient has weekly meetings with his or her treatment team to address any medical or psychological issues as well as concerns about release/discharge. Treatment teams are in constant communication regarding treatment updates for each individual patient. Without each of these pieces and unique perspectives, some area of knowledge and guidance would be missing. No one person can possibly manage all the necessary aspects of a patient's life – physical health, mental health, insurance, legal concerns, housing needs, familial ties, etc. The collaborative care model would be more successful in fully supporting a mentally ill patient and has been shown to increase mental health care access, lower medical costs, and improve patient outcomes (Satcher,

Kennedy, & Reed, 2016). In order for collaborative care models to be properly implemented, however, individuals must first be willing to go to the doctor and seek treatment.

Media campaign to end mental illness stigma. Thirty-eight percent of African Americans do not seek mental health treatment for depression due to embarrassment or shame. Other barriers to treatment include denial, fear, and lack of knowledge about the problem and treatment (MHA). One way to help resolve these barriers to treatment would be to create a mass media campaign, directed especially at low income and minority communities, to end the stigmatization of mental illness and improve rates of preventative mental health care service utilization. This campaign would also need to focus on educating African Americans about different mental illnesses and their symptoms, as well as common factors that contribute to the development and onset of mental illness, such as stress, trauma, victimization, etc. It would be helpful to share national statistics about Americans, specifically African Americans, who suffer from mental illness and encourage people to see their primary care physician if they notice any changes or have any concerns. Instead of just focusing on the negative, the media campaign would also highlight some easy ways to positively contribute to mental health and hygiene. These include keeping a journal, setting short and long-term goals, practicing breathing exercises for a few minutes each day, and engaging in small acts of kindness. A campaign of this nature would require some high profile anecdotes and promotion in the form of TV commercials, radio advertisements, social media posts, and other various forms of advertisements. For example, it would be beneficial to have prominent and high-profile African Americans from various walks of life promote the campaign. This was a successful part of the “Citizen Change” campaign led by P. Diddy, which is more widely recognized by its slogan: “Vote or Die!” The campaign used celebrity messaging to encourage youth voting, and it worked – the youth vote increased by 4.6 million from the 2000 election to the 2004 election (Vargas, 2004). Perhaps a consolidated effort to amplify the voices of widely known African American actors, musicians, politicians, athletes, writers, and authors would be able to have the same success in promoting

knowledge about mental health, mental illness, and the use of mental health care services. In order to properly promote and effectively validate this messaging, we must work to make healthcare, especially mental health care, actually accessible to low-income, African American communities. This means placing treatment centers and mental health clinics in the communities where the target populations reside because many systems of care are simply not located in proximity to where African Americans reside (Donvan, 2012).

Concluding Reflections: Ethical Obligations to Address the Problem

Though the numerous policy proposals contained in this paper are certainly neither exhaustive nor sufficient to end mass incarceration in its entirety or perfect America's mental health care system, I believe they are positive places to start. In the effort to end mass incarceration, there has been a failure to focus on mentally ill individuals and a focus on using a purely economic line of reasoning for ending mass incarceration. While there are economic benefits resulting from investment in many, if not all, of the policy proposals recommended above, there are more compelling non-economic reasons for why the U.S. should embrace these policy proposals in order to effectively end the mass incarceration, specifically of the mentally ill. One clear example of this economic, cost-savings approach is in Chairman Paul Ryan's 2014 policy proposal, "Expanding Opportunity in America" (2014). His plan suggests a number of strategies to more effectively use federal money to better the lives of and provide tools of empowerment for the poor in America. On the topic of criminal justice, the report says:

A growing body of research exposes the high costs of incarceration. To help low-risk, nonviolent offenders re-enter society, rebuild their families, and pursue careers, this proposal would revise mandatory-minimum guidelines and couple expanded enrollment in rehabilitative programming with an earned-time-credit system in federal prisons. (Ryan, 2014, p. 7)

The language of this proposed reform is essentially all based on economic outcomes and validates decreasing mass incarceration only for “low-risk, nonviolent offenders...in federal prisons.” There is absolutely no acknowledgement of the pervasive issue of the mass incarceration of mentally ill individuals, many of whom do not even have any family to rebuild. Many other incarcerated mentally ill individuals have been charged with violent crimes after becoming physical with another person, or a police officer, in the midst of a behavioral crisis, as previously discussed.

Ethical Obligations to Address Carceral Aspects of the Problems: Liberty Principle

Because our societal obligations extend beyond concerns of cost alone, we ought to expand our reasoning for ending mass incarceration beyond the narrow perspective of cost-benefit analysis. Particularly, we must expand our consideration to focus on the unjust mass incarceration of the mentally ill and its consequences for the rights, liberties, and lives of distinct individuals. Anyone committed to the American ideals of equal opportunity and certain inalienable rights should recognize that freedom from unjust incarceration and equal access to health, including mental health care, are essential to fulfilling our nation’s creed. We have a moral responsibility to properly treat currently incarcerated individuals for their mental illnesses, divert them from incarceration if they commit crimes, and implement more robust preventative mental health care in at-risk communities.

Our criminal justice system can only be perfectly just if incarceration is always used as a fair punishment that is proportionate to the crimes committed. However, setting aside the idea that we could ever achieve perfect justice, we should still work towards a system that is sufficiently just. With this in mind, the mass incarceration of mentally ill individuals is neither fair nor just. John Rawls’s theory of justice and his thought experiment concerning the original position and the “veil of ignorance” serve to help us create abstract principles that will allow us to both critique our current system and also set up principles governing our conception of justice going forward. In the original position, contractors, or citizens, create and agree upon what they believe to be good conceptions of a fair and just society when placed behind a veil of ignorance. The veil of ignorance serves to make all

contractors blind to their own race, SES, gender, health status, religion, and overall position in society (Loury, 2008). The governing principles adopted by these blind contractors would become the principles of justice in any society that utilizes them, because they would have been arrived at fairly behind the veil of ignorance. Rawls makes the claim that these unbiased, rational, self-interested contractors would agree to, among other principles, basic liberties for all (e.g. political liberty and freedom from arbitrary arrest and seizure), fair equality of opportunity, and, simply put, some form of a social safety net that serves to benefit the least advantaged (Rawls, 1999). Thus, a reasonable person placed behind this veil of ignorance would agree to certain abstract principles to ensure fairness. In effect, if he could turn out to be any person in society, including a sexually victimized African American woman with schizophrenia living in an area of concentrated poverty, then he would almost certainly not agree to a social contract through which he could potentially be untreated, stigmatized, incarcerated, or extensively held against his will based on his mental illness, the possession over which he has no control.

In essence, my argument here echoes that of Glenn Loury, who similarly invokes this Rawlsian thought experiment in his book, *Race, Incarceration, and American Values*. Loury uses the veil of ignorance to highlight the fact that we would all likely pick arrangements that respected the humanity of each individual, even that of criminal offenders (Loury, 2008). On the topic of justice for criminal offenders, Loury also writes, “when we hold a person responsible for his or her conduct...we need also to think about whether we have done our share in ensuring that each person faces a decent set of opportunities for a good life,” (2008, p. 32). Loury points out that the criminal justice system basically functions as a catchall “for individuals whose development has been neglected by other various social institutions,” among them, he cites mental health programs (Loury, 2013). Preventative mental health care access, discretion when it comes to arresting and sentencing mentally ill criminal offenders, and mental health treatment for currently incarcerated individuals each constitutes a unique opportunity for us to facilitate improvements in the lives of individuals

where it has been previously neglected. To validate his claim about responsibility, Loury also invokes John Rawls' social division of responsibility. Social division of responsibility posits that both individuals and citizens as a collective body are responsible for fulfilling our societal duties to ensure equal basic liberties, fair equality of opportunity, and access to primary goods, because any one person's life could turn out to be ours behind the veil of ignorance (Blake & Risse, 2008).

My argument is not restricted to a Rawlsian framework of justice. I believe that Iris Marion Young's conception of political responsibility in "Responsibility and Global Labor Justice," would also fit with Loury's Rawlsian notion of social responsibility. We each have a responsibility to help end structural injustices, even if all individuals are not directly responsible for those injustices. Young's concept of political responsibility is not backward looking because it does not depend on liability or causal responsibility, but rather, it emphasizes how we can work to change injustices right now and going forward (Young, 2004). Too often, human tragedies like Suzanne's story occur somewhere in the spaces between and within our judicial, mental health, and corrections systems – all of which are intended to operate in the public's interest and also on its dime. As taxpaying and voting citizens in the U.S., we have the power and shared responsibility to question and criticize how and why mass incarceration of the mentally ill has become a norm in our society. The problem only gets worse the longer we ignore it.

Ethical Obligations to Address the Health Aspects of the Problem: Opportunity Principle

Daniels, Kennedy, and Kawachi (2002) also use John Rawls's theory of justice as fairness to illustrate why the just distribution of social determinants of health is consistent with fair equality of opportunity. Social determinants of health (SDH) are defined as "the circumstances in which people are born, grow up, live, work, and age, as well as systems designed to deal with illness," (World Health Organization). SDH are the social, economic, and political forces that are often beyond the direct control of individuals; these include, but are not limited to, factors related to economic opportunity, education, family structure, housing, neighborhood, and access to social goods and

health care, and they help predict health outcomes (Cloud, 2014). We must consider mental health and mass incarceration to be very influential social determinants of health due to their undeniable presence and influence in the individual lives and communities of millions of Americans. Mass incarceration and untreated mental illness as SDH have created negative effects that have contributed to broken family structures, lowered economic mobility, entrenched inequality, and decreased access to quality education and housing.

Rawls believed that all humans have equal basic liberties and that society should always work towards guaranteeing fair equality of opportunity. Inevitable inequalities should only exist insofar as they function to help make the least advantaged groups among us as advantaged as possible; this concept is known as the difference principle, and Rawls believes that contractors in the original position would also agree to this principle of justice. Daniels et al. (2002) advocate for a system of universal access and claim that “some priority must be given to preventing, curing, or compensating for the worst impairments of normal functioning,” (p. 30). As I have argued here, mental illnesses, especially serious mental illnesses, are often overlooked or forgotten as some of the worst and most pervasive impairments of normal functioning. To take us back to the opening case, Suzanne’s mental health was impaired by a number of factors, including her lack of treatment, and was made worse by her subsequent incarceration. Her life effectively stopped when she was arrested in December and has yet to resume because she is still being held at Western State Hospital. Suzanne’s impairment of normal functioning demonstrates an injustice in our system and a lack of fair equality of opportunity.

There is no current, realistic way to eradicate mental illness or ensure completely equal distribution of mental illness because some individuals are simply genetically predisposed, among a number of other reasons. However, knowing that achievement of a perfect, ideal societal arrangement is impossible does not mean that we should not work towards actually achieving it by improving the lives of individuals in achievable ways. We are capable of helping to make positive

changes in equalizing the distribution of mental health by minimizing the trauma of incarceration and the potential dangers of police encounters, as well as removing barriers to equal treatment, such as the stigmatization of mental illness in African American communities and disparities in insurance coverage.

If all citizens need liberty, opportunity, and social bases of self-respect, among other primary goods, to have fair equality of opportunity, then health status and the many SDH are crucial determining pieces in the range of opportunities available to individuals. Fair equality of opportunity requires that we do not cause harm to mentally ill individuals, which very basically includes not incarcerating and further traumatizing them based on an untreated mental illness. In light of Daniels et al.'s conclusions about justice and health, I also believe this means we have a positive duty to promote health by treating currently incarcerated mentally ill individuals, diverting mentally ill offenders from jails and prisons, and providing preventative mental health care. If the policy proposals outlined here result in the increased availability of mental health services to the currently incarcerated, fewer individuals being unjustly incarcerated, improved access to and embracement of mental health care, *and* the saving of taxpayer money, then I believe we should endorse and implement them. These policy proposals would result in more positive outcomes for individuals, like Suzanne, whose lives have been greatly affected by mental illness and the criminal justice system. The policy proposals would also serve to raise awareness about the issue of mass incarceration of the mentally ill and affirm and promote the dignity of this often marginalized group of Americans. I have also established that thinkers such as Rawls, Daniels et al., Loury, and Young would likely agree that we should treat the issue of mass incarceration of the mentally ill not just as a cost-saving opportunity, but also as a social responsibility that we have to ensure the basic liberties and fair equality of opportunity for all Americans, regardless of race, SES, gender, religion, or health status - physical or mental. We owe it to individuals like Suzanne, who are often disadvantaged in multiple

ways, to implement the policies outlined in this paper and commit ourselves to making our criminal justice system and access to mental health care more just and equitable for all.

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